Fee Schedule FAQs – Georgia Workers' Compensation

REV 4.29.2022

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GENERAL

What is the most recent effective date?

The most recent effective date for the Georgia Workers' Compensation Medical Fee Schedule is 4/1/2022.

What is the fee schedule based on?

The fee schedule is based on:

- 2022 Current Procedural Terminology (CPT)
- Resource Based Relative Value Scale (RBRVS) multiplied by a conversion factor statistically determined from charge data in the state of Georgia
- Medicare severity Diagnosis-Related group (MS-DRG) for inpatient bills
- Medicare Outpatient Prospective Payment System (OPPS) and ambulatory payment classification (APC) groups plus markup
- Non-Emergency Transportation Fee Schedule with state-specific codes and maximum allowble reimbursement values.

Where can the fee schedule rates be found?

The state utilizes Fair Health to publish electronic and hard copies of their fee schedule. It is available on the state website at : https://georgiawc.fairhealth.org/

Does the state adopt NCCI?

Yes, the State of Georgia adopts the National Correct Coding Initiative Edits for practitioners and hospitals.

Does the state allow payment greater than billed charge?

No, the medical fee schedule calculates payment at the lesser of the provider's billed amount and the Maximum Allowable Reimbursement (MAR).

Is balance billing allowed?

No, Georgia State Board of Workers' Compensation prohibits a medical provider from attempting to collect payment from the injured worker for medical treatment.

"No physician, hospital, or other qualified health care provider shall bill the employee for authorized medical treatment. If an employee fails to notify a physician, hospital, or medical supplier that he/she is being treated for an injury covered by workers' compensation insurance, such provider of medical services shall not be civilly liable to any person for erroneous billing for such covered treatment if the billing error is corrected by the medical provider upon notice of the same. If a provider's charge is greater than the maximum allowable reimbursement (MAR), the provider must not bill the employee or the employer/insurer for the difference. The fees listed in the fee schedule represent all-inclusive and global fee amounts."

Does the state have any state reporting requirements?

No, the Georgia State Board of Workers' Compensation does not require state reporting.

Does the state have any EOR requirements?

Yes, a payer's Explanation of Review (EOR) shall contain sufficient information to allow the medical provider of goods and/or services to determine whether the amount of payment is correct and whom to contact regarding any related payment questions.

Please see the Georgia Workers' Compensation Medical Fee Schedule for a list of information that must be included on the EOR.

Does the state have any bill certification requirements?

The Georgia State Board of Workers' Compensation does not have any bill certification requirements.

Does the state have any statute of limitations for submitting a medical bill?

The Georgia State Board of Workers' Compensation Rule 203 (b)(1) states the following:

A medical provider or an employee who has incurred expenses for healthcare goods and services or other medical expenses shall submit the charges to the employer or its workers' compensation carrier for payment within one year of the date of service. In the event that the claim or the expense is controverted, the medical expenses or request for reimbursement must be submitted for payment within one year of the date of service or within one year of the date that the claim is accepted or established as compensable, whichever is later. Failure by the medical provider or employee to submit expenses within the time prescribed shall result in waiver of such expenses.

If the bill is not received within one year of the date of service, CORE is automated to allow $0.00 and assign RC 7Y (Provider shall submit a bill for services rendered, with supporting documentation, within one year of the date of service) for explanation.

Does the state have any payment time limits?

Yes, payment shall be made within 30 days from the date of receipt of charges.

How are unlisted codes and/or "by report" codes to be paid?

For a service or procedure not listed in the fee schedule, the provider should bill with an appropriate unlisted procedure code and report documenting the nature, need, and complexity. Payment will be determined based upon usual, customary, and reasonable charges.

What should be done if the provider bills an incorrect code?

The State of Georgia does not provide guidance for billing with incorrect codes.

Does the state guidelines allow down-coding?

No, the Medical Fee Schedule mandates that carriers may not down-code any bill that is submitted.

Does the state accept/recommend any usual and customary databases?

The Georgia State Board of Workers' Compensation does not regulate or recommend any specific usual and customary database.

What are the rules for out-of-state provider reimbursement?

The Medical Fee Schedule does not address reimbursement for out-of-state provider services. The fee schedule is only applicable for providers within the State of Georgia.

Has the state adopted a medical treatment guideline?

No, the Georgia State Board of Workers' Compensation has not adopted medical treatment guidelines.

ANESTHESIA

Reimbursement for anesthesia services is calculated as:

[Base Unit + Time Unit + Qualifying Circumstances + Physical Status modifier value] * CF

= Anesthesia Fee

Anesthesia services must be reported with the appropriate modifiers to indicate if the service was personally performed, medically directed or medically supervised.

Modifier	Description	Payment
AA	Anesthesia Services performed personally by the anesthesiologist	100%
AD	Medical Supervision by a physician (anesthesiologist not present); more than 4 concurrent anesthesia procedures	(3 Base Units + time units) * 50%
	Medical Supervision by a physician (anesthesiologist is present); more than 4 concurrent anesthesia procedures	(3 Base Units + time units + 1 time unit for induction) * 50%
G8	Monitored anesthesia care for deep complex complicated, or markedly invasive surgical procedures	Informational only
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition	Informational only
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50%
QS	Monitored anesthesia care service	Informational only
QX	CRNA service; with medical direction by a physician	50%
QY	Medical direction of one certified registered nurse anesthetist by an anesthesiologist	50%
QZ	CRNA service: without medical direction by a physician	100%
GC	Services have been performed by a resident under the direction of a teaching physician.	Informational only
	The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements in section 9789.18.2. One of the payment modifiers must be used in conjunction with the GC modifier.	

The application is automated to calculate reimbursement for anesthesia services when the anesthesia code and modifier are entered into the system. In CORE, anesthesia time is entered as minutes in the **Time** field. Time units are computed by dividing the reported anesthesia time by 10 minutes. Five (5) minutes or more would be considered a significant portion of time and rounded up to the next time unit.

When applicable, Physical Status and Qualifying Circumstances can be billed and will be reimbursed based off the following values below:

Physical Status Modifier	Description	Unit Value
P1	A normal, healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

Qualifying Circumstance	Description	Unit Value
99100	Anesthesia for a patient of extreme age, younger than 1 year or older than 70	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency conditions	2

SURGERY

Multiple and Bilateral Procedure Rules

Multiple and bilateral surgical procedures performed on the same day, by the same practitioners may be subject to multiple surgery reductions:

- 100% for the first or major procedure, or provider's charge, whichever is less
- 50% for each additional procedure, or provider's charge, whichever is less.

Assistant Surgery

Assistant surgery ***by a physician*** -

- Shall be billed with modifiers -80, 81, or 82.
- If payable, reimbursement is 20% of the fee schedule amount.

Assistant surgery ***by a non-physician practitioner*** (physician assistant, nurse practitioner or clinical nurse specialist) -

- Shall be billed with modifier –AS, or -PE.
- If payable, reimbursement is 10% of the fee schedule amount.

Eligibility for payment is determined by the Medicare National Physician Fee Schedule Relative Value File.

Assistant Surgery flags:

Asst Surg	Description	CORE Processing
0	Documentation of Medical Necessity required	Deny with **RC 4D** (Documentation required)
1	Assist-at-surgery services are not payable	Deny with **RC 91** (Service Not Allowed)
2	Assist-at-surgery services may be paid	Recommends Assistant Surgery Payment
9	Concept does not apply	Deny with **RC 91** (Service Not Allowed)

Co-Surgery

When two surgeons perform a specific procedure, each surgeon will report the surgical procedure with modifier -62 to indicate co-surgery. Each surgeon is reimbursed at the lesser of the billed amount and **75% of fee schedule** value for the surgical procedure.

Team Surgery

When a team of surgeons (three or more) work together to complete a complex surgical procedure, each surgeon will report the surgical procedure with modifier 66. If documentation of medical necessity is substantiated, each surgeon's services should be paid "by report."

Follow Up Days

The fee schedule utilizes the RBRVS payment guideline for **Global Days**:

Glob Days	Surgical Package
000	E/M services on the day of surgery are generally not payable
010	E/M services on the day of surgery and during the 10-day post-operative are generally not payable
090	E/M services 1-day preoperative and within the 90-days post-operative are generally not payable
XXX	The global concept does not apply to the code
YYY	The carrier is to determine whether the global concept applies
ZZZ	Add-on code. Global days are based on the primary procedure

RADIOLOGY

Where applicable, the fee schedule has separate rates for the whole component, technical component and professional component of radiology procedures.

LABORATORY AND PATHOLOGY

Where applicable, the fee schedule has separate rates for the whole component, technical component and professional component of pathology procedures.

MEDICINE

Physical Medicine

The following treatment limitations should be followed per visit, unless prior authorization has been obtained:

- Modalities only - No more than two (2) codes on the same visit
- Modalities and Physical medicine procedures - No more than four (4) codes total on the same visit.

EVALUATION AND MANAGEMENT

The fee schedule uses CPT codes 99241-99245 for outpatient consultations and 99251-99255 for inpatient consultations.

PHYSICIAN EXTENDERS (PE)

The Physician assistant (PA), nurse practitioner (NP) and clinical nurse specialist (CNS) are reimbursed at 85% of the fee schedule amount for their services.

Modifier –PE should be used if billing through a physician. CORE is automated to reimburse 85% of the fee schedule when modifier –PE is appended to the evaluation and management service.

Please reference the **Surgery section** for assist-at-surgery services by non-physician practitioners.

AMBULANCE

The Fee Schedule lists rates for both urban and rural depending on ambulance point of pickup.

CORE is automated to calculate the correct rate based on the zip code entered within the Ambulance Zip field.

DENTAL

The state does not provide fee schedule rates for dental services. Dental services are payable "by report."

DURABLE MEDICAL EQUIPMENT/PROSTHETICS, ORTHOTICS, SUPPLIES (DMEPOS)

DMEPOS are calculated at the lesser of the billed amount and at 150% of the wholesale vendor invoice.

INPATIENT HOSPITAL (ACUTE-CARE)

Inpatient admissions in an *acute-care hospital* are reimbursed as follows:

[CMS DRG Relative Weight x Base Rate] = Inpatient Hospital Payment Amount

Any MS-DRGs outside of the fee schedule are calculated at 62.23 percent of charge. In addition, the fee schedule lists hospitals which are MS-DRG Exempt in Subsection D of the Inpatient Fee Schedule.

Outliers

The bill may qualify for an additional outlier payment if the hospital's costs exceed the outlier threshold. The formula for outlier payment is:

[Total Billed Charges – DRG payment – Implants if applicable – 40,000.00]

If Outlier Charge is greater than 0, then Outlier Payment = 0.45 x Outlier Charge.

Implants

Surgical implantables will be reimbursed based upon invoice cost excluding taxes and additional fees.

Trauma

The fee schedule does not address special payment provisions for trauma admissions or trauma facilities.

Critical Access Hospitals

The fee schedule does not address special payment provisions for critical access hospitals.

Out-of-State Inpatient Stays

The fee schedule does not have specific payment provisions for out of state inpatient stays. Thus, CORE will calculate reimbursement based on the Inpatient Hospital MS-DRG rates.

SPECIALTY FACILITY/SERVICES

Rehabilitation, Psychiatric, Long Term Care Hospitals, Skilled Nursing Facilities

Reimbursement for inpatient rehabilitation services (MS-DRG 945 and 946) should be negotiated by the facility and the payer prior to services being rendered. If a payment rate has not been negotiated prior to services being rendered, the hospital will be reimbursed based on the MS-DRG payment schedule.

Reimbursements for the other facility types are not regulated by the State of Georgia.

Data Entry Requirements

The following guidelines identify the key fields required for accurate inpatient pricing in CORE.

On the **Provider Record** screen:

- **Prov Type** = 10

On the **Data Entry** screen:

- **UB04** = Y

On the **Additional Info** screen:

- **Date Admit** - Enter the Admission Date (FL12 on the UB-04)
- **Bill Type** - Enter the Type of Bill (FL4 on the UB-04)
- **B.O.S. Date** - Enter the Beginning date (FL6 on the UB-04)
- **E.O.S. Date** - Enter the Ending date (FL6 on the UB-04)
- **Facility Type** = A (Acute Care Facility) or O (use for all other facility types)
- **Billed DRG** - Enter the DRG (FL71 on the UB-04)

On the **DRG Header Input** screen:

- **DRG Y/N** = Y (Acute Care Facility) or N (use for CAH, Rehab, Psych, LTCH)
- **Pat Status** - Enter the Discharge Status (FL17 on the UB-04)
- **Medicare ID** - Enter the facility's Medicare Provider Number (MPN)
- **DRG Code** - Auto-populates per the DRG Grouper output. User may manually override.

When entering the revenue codes and charges:

- Key all lines presented on the bill
- **POS** = 21

CORE will calculate payment according to the fee schedule and RC ZE is applied to the lines.

DRG Grouper Requirements

CORE contains a MS-DRG Grouper program. The grouper program requires the following data elements in order to accurately compute a MS-DRG in the **DRG Code** field on the **DRG Header Input s**creen:

1) Patient **Date of Birth** (in Claim Record)
2) Patient **Gender** (in Claim Record and in DRG Header Input screen)
3) Patient **Discharge Status** (in the DRG Header Input screen)
4) ICD **Diagnosis Codes** and POA Indicators (from FL67 A-Q on the UB-04)
5) ICD **Procedure Codes** (from FL 74 A-E on the UB-04)

NOTE: If any of these requirements are not met, the grouper will apply DRG 999. User may manually override.

OUTPATIENT HOSPITAL & AMBULATORY SURGERY CENTER

Outpatient hospital and ASC services are reimbursed per the Outpatient Prospective Payment System (OPPS) under Medicare.

The maximum allowable reimbursement is the CMS rate for each APC group multiplied by state markup.

Outpatient Hospital / Ambulatory Surgery Center

Generally, emergency room visits, surgical procedures and services that are an integral part of the ER or surgery visit are reimbursed as follows:

[**Medicare OPPS APC weight * state markup] = Facility Fee**

Other outpatient services are reimbursed according to the medical fee schedule (Clinical Laboratory, DMEPOS, etc).

Implants

Certain high cost device-intensive related outpatient procedures are assigned a comprehensive APC and designated status indicator J1.

Devices and implants are reimbursed based on the invoiced cost of each item excluding taxes and handling costs.

Clinical Diagnostic Laboratory Testing

When clinical diagnostic laboratory tests are performed in an outpatient hospital setting without other hospital outpatient services, the clinical diagnostic tests will be reimbursed based on the Physician Schedule's PROF MAR column found in the Pathology and Laboratory section.

SPECIALTY FACILITY/SERVICES

Rehabilitation, Psychiatric, Long Term Care Hospitals

Reimbursement for these outpatient facility types are not addressed within the fee schedule.

Skilled Nursing Facility (SNF)

Reimbursement for this facility type is not addressed within the fee schedule.

Home Health Agency

CORE is automated to calculate reimbursement for Home Health services when an appropriate Provider Type is used and a Home Health CPT code is entered into the system.

In CORE, hours of care are entered in the Units field. CORE is automated to calculate the correct reimbursement per hour of service.

Reimbursement for prescription drugs is at the current average wholesale price (AWP) published by Medi-Span, including one dispensing fee per National Drug Code (NDC) per day.

CORE is automated to reimburse the correct generic or brand name dispensing fee according to the Fee Schedule.

Repackaged Drugs

Repackaged drugs are reimbursed based on the NDC of the original drug product.

Compound Drugs

The maximum allowable reimbursement for the compound drug will be the sum of AWP for each active ingredient minus 50%, plus a single compounding fee.

INDEPENDENT MEDICAL EXAMINATIONS (IME)

The employee has the right to one IME performed at a reasonable time and place by a duly qualified physician or surgeon designated by the employee and paid for by the employer/insurer.

Payment for IMEs will be based on time spent in the review of medical records, test reports, a physical examination, and written report regarding the medical condition of the injured employee.

Code	Description
IME01	Prepayment of first 2 hours
IME02	Subsequent hour(s) beyond the 2 hour prepayment
IME03	No show fee

CORE is automated to reimburse **$600.00** for the first hour, **$150.00** for each additional 15 minutes, and **$150.00** for a no show fee.

REPORTS

Special repots such as insurance forms that convey more than the information transmitted in usual medical communication or standard report forms should be reported with CPT code 99080.

CORE is automated to reimburse CPT code **99080** a maximum allowable reimbursement (MAR) of **$60.00**.